NEWTON PARKS AND RECREATION DEPARTMENT
OUTDOOR ADVENTURE
MEDICAL EXAMINATION

Please Note: Many doctor's offices have a standard medical examination print out for summer camps. These forms will be accepted in lieu of this medical examination from as long as they have all of the below information. Examinations must be dated July 2, 2011 or later in order to be accepted.

Name_____ Birth Date_____

Age_____ Sex_____ Grade Entering_____ School_____

Parent/Guardian_____

Home Address_____

Home Phone_____Work_____Cell_____

Home Phone_____Work_____Cell_____

Emergency Contact_____ Relationship_____

Home Phone_____Work_____Cell_____

****

HEALTH HISTORY: To be filled out by a licensed physician. This examination should be performed within one year of the starting date of this program. Check if appropriate and give approximate dates.

ASTHMA_____ ATHLETES FOOT_____ CHICKEN POX_____

MUMPS_____ MEASLES_____ SINUSITIS _____

POLIO_____ FAINTING_____ CONSTIPATION_____

FREQUENT COLDS_____ EAR INFECTIONS_____ SORE THROATS_____

GLASSES____ VISION PROBLEMS_____ HEAD LICE_____ WHOOPING COUGH___

OPERATIONS_____ STOMACH TROUBLE_____

HEART TROUBLE _____

SEIZURES (type and frequency)_____

_____

IMMUNIZATION HISTORY: This is a record of dates of basic immunizations and most recent booster doses. This must be completed in full prior to the start of the program.

DPT SERIES_____/_____/_____ DPT BOOSTER_____

TETANUS_____ TETANUS BOOSTER_____/____/____

POLIO/OPV SERIES_____ POLIO BOOSTER_____

MEASLES (2 live doses necessary after 12 months) _____/_____

MUMPS_____ RUBELLA_____

MMR_____ MANTOUX TEST _____

HEPATITIS B_____/_____/_____

****

ALLERGIC REACTIONS:

BEE STINGS_____ PENICILLIN_____ OTHER_____

FOOD ALLERGIES_____

CURRENT MEDICATIONS_____

_____

ANY RESTRICTIONS_____

_____

****

The above information contained in the immunization and Health History is correct to the best of my knowledge. The person herein described is in good physical health and has my permission to engage in all prescribed program activities, except as noted above. This form must be signed by a Physician with respect to immunization history.

_____ _____

PHYSICIAN'S SIGNATURE DATE

PHYSICIANS ADDRESS_____

PHYSICIAN'S PHONE NUMBER_____